Medicaid Beneficiaries in Health Maintenance Organizations

An Annotated Bibliography

RA
413
.5
U5
M43
1981

RA
413.5
.U5
M43
1981
c.2

MEDICAID BENEFICIARIES IN HEALTH MAINTENANCE ORGANIZATIONS

AN ANNOTATED BIBLIOGRAPHY

THE AMERICAN PUBLIC WELFARE ASSOCIATION AND
THE DEPARTMENT OF HEALTH AND
HUMAN SERVICES, DECEMBER, 1980

MEDICAID BENEFICIARIES IN HEALTH MAINTENANCE ORGANIZATIONS: UTILIZATION, COST, QUALITY, LEGAL REQUIREMENTS

AN ANNOTATED BIBLIOGRAPHY

EDITORS

MARGO L. VIGNOLA, M.A., AMERICAN MEDICAL INTERNATIONAL, INC.

GEORGE B. STRUMPF, M.P.A., GROUP HEALTH ASSOCIATION OF AMERICA, INC.

FOREWORD

For some time the Department of Health and Human Services has been interested in increasing the enrollment of Medicaid eligibles in health maintenance organizations (HMOs). Within the past year, we have devoted extra effort to overcoming some of the barriers that have prevented enrollment and I believe we are making some real progress.

This summary of the extensive bibliography about Medicaid Beneficiaries in HMOs should aid the efforts of State Medicaid agencies and HMOs as they seek to establish working relationships and bring comprehensive health care services to Medicaid beneficiaries. It describes the historical experience of Medicaid enrollment in HMOs, and identifies the difficulties encountered by State Medicaid agencies and by HMOs in developing a mutually beneficial contracting arrangement.

This information will, no doubt, help to avoid some of the potential pitfalls and provide a useful framework upon which to build a successful relationship.

Howard R. Veit
Director
Office of Health Maintenance
Organizations

SECTION I

INTRODUCTION: THE EVOLUTION OF MEDICAID CHARACTERISTICS

The Medicaid program -- Title XIX of the Social Security Act -- was enacted in 1965 to provide health care for the indigent. Essentially a financing mechanism, Medicaid is a Federal-State program directly linked to the public assistance (cash grant) titles of the Social Security Act.* In 1979, federal, state and local expenditures for Medicaid totaled $22.796 billion and are presently rising at an annual rate of 15 percent.

The original goal of the Medicaid program was broad: to bring the poor into "mainstream" medical care by eliminating financial constraints. The underlying assumption was that limited income was the primary deterrent to seeking medical care and, therefore, providing payment for services would assure access to the health care delivery system. Even a brief review of Medicaid's history indicates that this premise was not well founded. Too many other troublesome factors influencing health services use are not ameliorated by the simple availability of funds. The lack of available health resources (particularly in those areas where indigent people live), the lack of knowledge on the part of eligible persons about the health delivery system, and the tremendous impact of nutrition and environment on health, are factors largely unaffected by medical care. Both Medicaid and Medicare (Title XVIII) were grafted onto the existing organization of health services and were generally patterned after traditional health insurance programs. Neither program attempted to modify the supply or organization of services. As a result, the Medicaid program quickly assumed the characteristics of the private health delivery system. A preponderance of resources (61 percent) was consumed by institutional care; the utilization of primary care and preventive services (although covered by the program) remained fairly low, and the traditional sources of health services for the indigent -- hospital outpatient and emergency departments, and clinics -- were not replaced by private resources. Recent studies have shown that while many persons have received services because of Medicaid, the major problems of access to them and "two-tiered" (one for the poor, one for the general population) medical care remain (1, 17).

As the failure of Medicaid to assure access has become apparent, two additional concerns have also emerged -- high costs and poor quality. Program costs have long been a source of concern to both States and the

* Title IV-A -- Aid to Families With Dependent Children (AFDC)
Title XVI -- Aid to the Blind, Aid to the Disabled, Aid to the Aged

Federal Government. Medicaid is considered one of the "uncontrollables," i.e., programs whose expenditures are not subject to the Congressional appropriations process. Further, Medicaid is subject to the inflationary pressures that plague the entire health industry at the same time that it is faced with the rise in the number of eligible person to 22.9 million. Cost increases are even more pronounced during periods of high unemployment, such as the country has undergone in recent years -- and is still battling. Finally, costs have risen as utilization of health services has expanded.

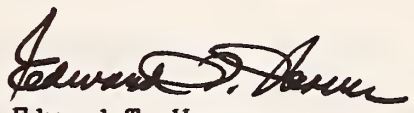
As expenditures have increased, so has concern with the quality of Medicaid services. There have been many scandals exposing the poor quality of services provided by nursing homes, "Medicaid mills," and many other health facilities. Fraud and abuse have become closely identified with program providers.

A variety of problems associated with the program have been cited for Medicaid's partial failure to meet its original objectives, among them cost reimbursement of hospitals; poor claims processing and management systems; insufficient monitoring of services. However, many believe that reliance on fee-for-service medicine, coupled with virtually no attempt to modify the supply or organization of health services, has led to many of the program's problems, as Medicaid seems to be locked into traditional financing and delivery of services. In recent years, several States have turned to alternative delivery financing systems as a means of improving the way in which the program operates. Principal among these alternatives is prepaid health care -- more popularly termed "health maintenance organizations" (HMOs). These entities, which modify both the organization and financing of health services, have become increasingly popular since their initial development in the 1920s and 30s. States have been allowed to contract with HMOs since 1967 and, while initial involvement was limited, 15 States presently maintain contracts covering some 300,000 enrollees.

This document discusses the experience of Medicaid beneficiaries in HMOs. Particular attention is given to utilization, cost, and quality. A number of related topics are also examined: the administration of Medicaid-HMO contracts; the impact of Federal and State regulation (particularly P.L. 93-222 -- the Health Maintenance Organization Act as amended in October 1976 and 1978); and the influence of Medicaid on the development of HMOs.

The document builds on a 1973 publication, An Annotated Bibliography of HMO Utilization by Title XIX Recipients, August 1973, developed by Arthur Young & Co., for the Department of Health, Education, and Welfare for distribution at the National Conference for Developing Title XIX-HMO Contracts held in Miami, Florida, September 1973. As a staff member of the American Public Welfare Association, Inc., Margo Vignola collaborated

with Mr. George Strumpf in the expansion of the earlier publication in the hope that State and county welfare agencies, existing and developing HMOs, and policymaking bodies will be assisted by a current and extensive discussion of the experiences of Medicaid beneficiaries in HMOs. The editors have been updating the bibliography as close to the time of publication as possible. Readers will note that following the first 81 citations a listing of current additional references has been included. It is a pleasure to cooperate with the Department of Health and Human Services in the publication of this information.



Edward T. Weaver
Executive Director
American Public Welfare
Association

SECTION II

MEDICAID AND HMOS: A BRIEF OVERVIEW

Several characteristics of prepaid health care are vastly different from the traditional fee-for-service structure utilized by most Medicaid eligibles. These unique attributes make the linkage between Medicaid and HMOs most advantageous, particularly in light of the increase in the program's expenditures over time.

HMOS: THE BASIC CHARACTERISTICS

The term "health maintenance organization" is used broadly here, in the sense that it is not limited to the Federal legislation and regulations. "Health maintenance organization" encompasses a variety of organizational structures and methods to provide prepaid health care. Though all HMOs do not share the same operational framework, most do have certain key elements in common. An HMO:

1. Provides or arranges for a range of comprehensive health care services and guarantees that these services will be available to its members;

2. Accepts prepayment for these services at periodic intervals;

3. Includes a provider group or groups -- either employing physicians directly or contracting with a separate entity which provides physician services;

4. In the case of group practice type HMOs, compensates physicians in a manner not related to the volume or number of services provided (not fee-for-service);

5. Most frequently uses community hospitals for inpatient care, or, in a few instances, owns a hospital facility or contracts with a third party insurer for inpatient care;

6. Uses a community rating system (if Federally qualified) to determine premiums. Members pay a fixed rate regardless of individual utilization;

7. Enrolls members on a voluntary basis;

ADVANTAGES AND DISAVANTAGES OF HMOS

The advantages of HMOs are largely due to their organization for providing

health care coupled with prepayment for services. Some of these benefits are:

1. In the case of group practice type HMOs, a more effective administrative structure, e.g., centralized, complete, non-duplication of records; more efficient use of manpower and capital equipment through sharing of facilities and coordination of available staff; appropriate utilization of referral services; productive administration that, for instance, frees physicians from the responsibility of billing.

2. An organizational commitment to facilitate access to ambulatory care and to early detection of disease by avoiding financial barriers such as deductibles or large co-payment requirements.

3. A capacity to provide for health education of subscribers and for continuing education of staff.

4. A reversal of the incentives inherent in fee-for-service medicine, particularly where third party reimbursement is available, for physicians and hospitals to provide hospital services that could be provided on an ambulatory basis. Most HMOs provide a larger offering of preventive health services; demonstrate lower rates of hospitalization and elective surgery, and, in some cases, shorter hospital stays than traditional forms of health care. These observed differences stand firm in studies using comparable populations.

5. The absense of incentives to hospitalize, usually noted where third party payment is available; for physicians and other providers to consider costs and to avoid overusing expensive facilities and resources.

6. An informal and formal structure of consultation and referral mechanisms that results from the ready availability of facilities and colleagues.

7. Health care more suited to consumer's needs, e.g., through greater accessibility provided by the systems organized means and facilities.

8. A shared use of resources and manpower that achieves more efficient care and includes a peer review and quality assurance system in its medical care processes.

9. The financing approach, based on principles of an enrolled population and a community rating system, that a) allows members

to budget for health care; b) ensures that the members are not penalized for appropriate heavy utilization of the system when necessary, can result in lower health expenditures for members as there are usually no deductibles or co-insurance; copayments are nominal and first dollar coverage is provided.

Many of these advantages are generated by altering the incentive structure of the present system of fee-for-service medicine, where income is directly proportional to the amount of service provided. Also, the non-economic pressures, such as peer group pressures and utilization review procedures, result in improved physician performance that is advantageous both to the members and the HMO.

All the advantages cited above attracted State agencies to HMOs -- and the nearly nine million persons presently enrolled voluntarily in some form of prepaid health care.

Descriptions of HMO theory and practice include some recurring criticisms. Inefficiencies have been noted that are usually related to the method of providing health care and to the size of the HMO. Among them are:

1. The fixed allocation of facilities and personnel (in the case of group practice HMOs) necessarily restricts the locations to which health care members have access. Often HMO members must learn different approaches to obtaining care than they were accustomed to in the fee-for-service sector.

2. Queues for different services can develop when membership demand is high and resources are restricted. The fee-for-service sector results in de-facto rationing of services based on ability to pay.

3. The HMOs' commitment to use specialized and expensive services appropriately requires optimum use of primary care practitioners. Patients accustomed to ready referral to specialists may perceive this approach as poor quality care or bureaucratic barriers to care.

4. HMO requirements defining how and when care is to be received may be confusing to less sophisticated members and thus may serve as deterrents to obtaining care or result in members resorting to out-of-plan health care whose costs are not covered.

5. Some critics state that the lower hospital utilization HMOs achieve is a result of HMO members having a better health status than non-HMO persons. When comparison are made, they are relevant only if matched populations are used.

6. It has also been claimed that out-of-plan expenditures occur that are not reflected in the various studies of HMOs. Usually out-of-pocket costs to insured persons are not obtainable to compare to total HMO costs.

7. The possibility exists for emphasizing cost savings at members' expense.

MEDICAID INVOLVEMENT IN HMOS: THE RATIONALE

Initial interest in prepaid health care for Medicaid recipients sprang from three concerns: cost, access, and quality (49). Several aspects of HMO appeared to satisfy problems inherent in Medicaid, as well as serve the program's ultimate objective of improving health care for indigent persons.

Accessibility and Availability

Few studies have been performed on the accessibility and availability of health services to Medicaid beneficiaries relative to other indigent persons not eligible for Medicaid. It is known, however, that a shortage of services exists in those areas with heavy Medicaid populations (largely inner city and rural regions) and those that are available consist largely of hospital outpatient clinics, neighborhood health centers, and emergency rooms. Few private physicians practice in these areas. Emergency rooms are used extensively since neither the private doctors nor clinics are available on a 24-hour basis (1, 2, 17). Recent studies have indicated that while Medicaid has improved the situation, access to care remains limited (1, 27). Recipients have particular difficulty in obtaining routine acute medical care (so-called primary care services). In addition, providers are frequently reluctant to treat beneficiaries because of the cumbersome administrative payment procedures and the relatively low rates of reimbursement.

Thus, despite the influence of Medicaid, certain health characteristics still mark indigent persons, partly because of the general lack of health care services' availability and accessibility:

1. The indigent have a higher incidence of chronic disease, hospitalization, and disability because of illness (loss of time from work and school) than the general population. Inadequate nutrition, housing, and health knowledge are frequently cited as major causes for these conditions -- but there is also the fact that people delay seeking medical attention until conditions become incapacitating. They then are disabled for a longer period of time and require more expensive and sophisticated treatment, some of which might have been avoided with earlier medical

attention. Thus, both recipient and the program suffer costly, time-consuming losses.

2. The health care resources that individuals do use are frequently inappropriate. Specialized emergency room service is expensive and inefficient. Hospitals are, in general, neither designed nor equipped to deliver such primary care services on a regular basis. See 1, above.)

HMOs provide continuously available primary care, emergency, and hospital services. Since HMOs promote easy access and early detection of illness, members are encouraged to seek medical care whenever necessary. Since HMOs assume financial risk, they seek the most efficient and appropriate means of care. Unnecessary hospital care is frequently eliminated or replaced by more appropriate modalities. (See next sections for expanded discussions on utilization.) Thus, recipients have both access to comprehensive health services and continuous contact with the health care delivery system. Since no claims would be filed and payment is not made on a fee-for-service basis, present disincentives to physician participation would no longer exist.

Utilization and Cost Savings

An almost universal characteristic of the HMO is lower hospital utilization than for populations covered by traditional health insurance mechanisms -- a characteristic attributable to HMOs avoidance, where possible, of relatively costly hospital care. For the most part -- as noted -- less expensive ambulatory care is substituted for hospital services and unnecessary elective procedures are avoided (53), resulting, obviously, in significantly lowered cost. Also, as noted previously, use of outpatient services is concomitantly increased for HMO members, with the likelihood of immediate cost savings.

In sum, early treatment of disease -- encouraged by the HMO philosophy and structure -- generates significant cost savings both for the program and the recipient in its avoidance of extended treatment at a later point in an illness and overuse of hospitalization.

Quality of Care

While the quality of care rendered in HMOs has sometimes given rise to controversy, its definition and actual measure remain ambiguous regardless of whether the care is provided by fee-for-service practitioners or HMOs. On the one hand, HMOs' advantages point to a generally higher level of care (53); on the other, service has been seen as impersonal. Moreover, given no accepted utilization standards, there are two viewpoints on the HMOs reported cost savings in the area of hospitalization. One view is

that unnecessary and inappropriate utilization is curbed, thus rendering overall better care at lower cost. In contrast, some view HMOs as too cost conscious, denying necessary care purely for the sake of reducing expenditures. Evidence to support the latter view has not been produced, however.

In fact, it appears that HMO services are superior to the alternatives available to persons on Medicaid. Services are more accessible to them, consequently they are likely to receive needed care more rapidly. Another point that enhances HMOs' value to Medicaid recipients is their mixed subscriber populations whose members are usually identified with a uniform card and treated the same -- the indigent are not separated or singled out when seeking services. Nor, as HMO members, are they subject to their usual limited choice of services that forces them to rely on emergency rooms and outpatient clinics. Such a reliance tends to create a dual track system of health care, one for middle and upper income groups and one for the poor. Again, while difficult to document, the quality and dignity of services in these settings has frequently been considered to be lower than that for the general population.

Finally, HMOs do have the capability to review ambulatory and in-patient services that many health systems, particularly those providing outpatient services, do not have. Quality assurance mechanisms are thus built into the provision and financing of health services that should mean the Medicaid beneficiaries receive a more satisfactory level of health care within an HMO.

Administrative Procedures

Administrative efficiency also can be generated by prepaid group practice plans because periodic, negotiated payments are made for comprehensive health services in advance (usually on a monthly basis). Fee-for-service billing is eliminated and an enormous volume of claims submission and processing avoided. Providers are not required to complete individual invoices and, consequently, administrative costs are significantly lowered for both the HMO and the Medicaid program.

A SLIGHT DIGRESSION: THE INTEREST OF HMOS IN MEDICAID

While it is readily apparent why States are interested in HMOs, the

reciprocal interest of HMOs in Medicaid is not as clear.* The administrative complexities alone (see Section V) would appear to be enough to dissuade many HMOs from seeking Medicaid contracts. However, the Medicaid program does represent an assured source of revenue to many, particularly in developing health care plans. A Medicaid contract may provide a steady cash flow while the HMO is seeking membership from other sources. This purely financial incentive may lead to program abuse, but in itself is probably the greatest influence on HMO contracts with Medicaid.

Some well-established HMOs seek Medicaid contracts to further their involvement and identification with the community. This more altruistic objective has fostered some of the longest standing relationships between States and HMOs. Presently there are 37 prepaid contracts in effect, including both cost and risk types of contracts.

SECTION III

MEDICAID ENROLLMENT IN HMOS: THE FIRST YEARS

Initially, the Medicaid program did not bring low income persons into HMOs. The first projects were largely supported by the Office of Economic Opportunity (OEO), a major arm of the "Great Society" programs of the late sixties. OEO funded neighborhood health centers (NHCs) to provide services to indigent persons and subsidized enrollment in existing health centers -- some of which were organized HMOs. The primary objective of these early programs was to improve access to and utilization of health services by these previously underserved persons. Early studies tended to focus on utilization alone since comparisons could be more readily made with past experience (14, 32, 58, 59, 66). Quality of care and cost frequently were not analyzed -- largely because information was not available to determine results accurately.

OEO and Medicaid populations have many similarities of age and sex composition, race, educational backgrounds, and general living situations. However, there are also important differences that may affect the outcomes of enrollment in HMOs, principally the fact that Medicaid recipients have financial access to other sources of care whereas OEO populations (to the extent they are not covered by Medicaid) generally do not. In addition,

* Note: P.L. 93-222 gives special preference (in terms of grants) to HMOs serving so-called medically underserved areas. Frequently, these generally rural and inner-city regions contain a high proportion of Medicaid recipients. Therefore, HMOs wishing to take advantages of of the statute's preferential treatment must seek contracts with State Medicaid programs (see Section VII).

certain populations are excluded from Medicaid regardless of financial need because they do not fulfill categorical requirements (aged, blind, diabled, AFDC). The people (single persons, so-called "intact families," and couples with no children) were not excluded from OEO coverage and may skew certain results.* These persons may exhibit a greater backlog of unmet need for medical services and thus use HMO or NHC services to a greater extent.

SOCIODEMOGRAPHIC CHARACTERISTICS AND UTILIZATION

Enrolled populations exhibited more different age distributions than the general area population (14, 31, 36, 43). Adults tended to utilize facilities (physicians and hospital visits) more than children (14, 20, 30, 31).

The studies indicated that indigent persons were mainly members of minority populations (black, Puerto Rican) and had a poor command of English. These groups tended to use services more once they enrolled in an HMO (58, 59). Researchers found also that ethnic composition relates to utilization regardless of other socioeconomic characteristics (59).

Both OEO and Medicaid populations have a higher proportion of females than the general population. Logically, females used services more than other covered adults (14, 20, 28, 30, 31, 59).

Both OEO and Medicaid populations tended to have larger families than the general population, and this proved to be a powerful indicator of utilization. The percentage of the populations using the service at least once decreases as family size increases (31).

UTILIZATION OF SERVICES: AMBULATORY AND PREVENTIVE CARE

The use of ambulatory services varied considerably, depending on the length of enrollment and previous utilization patterns. Studies in these areas seem to take wide swings also. Some noted that utilization by new enrollees exceeded that of comparable enrolled populations (30, 53) but, after an initial adjustment period, the rates of use levelled off (66). Utilization differences are most pronounced in younger populations, particularly of preventive services (28, 30, 58). The proportion of indigent populations receiving general health examinations increases dramatically upon enrollment in an HMO (5). Other studies noted few differences in utilization between indigent enrollees and the HMO's general population, even for new enrollees (36). On the other hand,

* OEO generally covered indigent persons within a defined area.

several studies showed that new enrollees exhibited lower rates of utilization than indigent persons who had been enrolled for a period, indicating a gradual increase in utilization over time (36, 40). One study found that Medicaid enrollees exhibited lower utilization rates than the general Medicaid population (25). These differences may be due to a number of factors, but especially the orientation or outreach services available to recipients (discussed below). Enrollees who are not familiar with HMO practices may utilize services less initially; if the HMO is not easily accessible, utilization may also be low. However, despite these variation in early utilization, virtually all the studies indicates that utilization over time approaches that of comparable non-indigent HMO populations (14, 30, 31, 36, 40).

UTILIZATION OF HOSPITAL AND OTHER SERVICES

Almost all studies indicated that hospital utilization is the same for indigent and general enrolled populations (30, 36, 63, 66). For some groups, usually Medicaid, this represented a reduction in the use of services to the HMO level (24, 28). Only one study reported that Medicaid eligibles' hospital use was higher than for the general HMO population (30). Another study also reported a reduction in the use of prescribed drugs (24, 28).

ACCESS, ATTITUDES, AND EDUCATION

OEO populations exhibited different patterns of utilization behavior from those of general subscribers in several areas. For example, they demonstrated a higher rate of "no-shows" for appointments and a greater incidence of "walk-ins," or unscheduled visits (31, 40). OEO enrollees utilized more services after hours and on weekends than general plan members (14, 31). These patterns would indicate that indigent persons are less familiar with the operation of an ambulatory care center and are accustomed to unscheduled services (e.g., hospital emergency rooms, outpatient clinics).

Attitudes concerning access, waiting times, continuity of care, treatment by physicians, and overall favorable impressions did not vary between OEO and non-OEO enorllees (43). In neighborhood health centers, in particular, recipients utilized services because of easy access, quality of care, and low cost (5, 43). One study noted that the proportion of indigent persons who postpone seeking medical care declines upon enrollment in an HMO (5). These results point to the probability that access to comprehensive care is more assured for enrollees in an HMO or neighborhood health center. They also appear to show that comparable care was not available before, hence the high rates of satisfaction and commitment, but a lack of familiarity with an organized delivery system.

HEALTH STATUS QUALITY: MORBIDITY AND MORTALITY

Quality is the most difficult aspect of health care services to measure. The classic indicator outcome is mortality. Three studies did find that death rates fell for Medicaid recipients enrolled in comprehensive care programs to lower than the rates of those receiving traditional modes of health care delivery. These limited results involve quality of care as well as other influencing factors (58, 59).*

Regarding morbidity, one study indicated that incidence of disease is comparable for indigent and non-indigent enrolled populations (14). Two studies noted, however, that for adult enrollees, utilization rates were higher for the OEO than for the general population (except for preventive services), and considerably higher for disease with high emotional content, chronic disease, injuries or accidents (30, 31). One could deduce that general population, indigent persons have a greater tendency and opportunity to seek medical attention (time costs are zero).

SUMMARY

Despite some basic differences in approach, most studies reveal one common characteristic: that utilization of services by indigent persons eventually matches that of comparable enrolled populations. This result, combined with other findings, has several implications for access, cost, and quality. Services seem to be more accessible to enrollees than other sources of health care. In particular, access to ambulatory and preventive care is enhanced. In terms of cost, the HMO does not appear to face greater financial risk with its indigent members, after an initial adjustment period, than with any other population. Therefore, an HMO need not expect excessive costs (due to higher utilization) from indigent populations. Reduced hospital utilization means substantial reductions in cost to a State Medicaid program -- thus providing a great incentive to pursue contracts. Finally, while results are inconclusive, declines in mortality rates for enrolled populations indicate that despite lower costs, quality health care for indigent populations in HMOs is superior to their other sources of care.

* An analytic review of quality of care studies of the past 20 years in The Group Health Journal, Vol. 1, No. 1, Winter, 1980.

SECTION IV

MEDICAID ENROLLMENT IN HMOS: THE RECENT EXPERIENCE

As the results of the OEO and early Medicaid experiments have become widely known, States' interest in Medicaid and HMOs has grown, spurred largely by a perceived and growing need to control costs. The uniform reduction in hospital utilization achieved by HMOs was seen as the principal advantage. It became apparent, too, that while Medicaid had improved access to health care, many recipients still relied on hospital emergency rooms and outpatient deparments as the primary sources of care -- both considered costly and inefficient. The implications of reduced mortality were also clear, that quality of care was at least equal to -- and likely better than -- most sources of care available to Medicaid recipients. The advantages of prepaid care attracted a number of States to consider and implement Medicaid HMO contracts.

Along with the new popularity, however, came a reliance on HMOs as one of the cost containment mechanisms. In 1971, California, in particular, adopted prepaid health care as one feature of Medicaid cost control. At the same time, funding for neighborhood health centers diminished, thus focusing much of the effort to enroll low income persons on Medicaid in prepaid health plans. New concerns and problems, discussed in more detailed below, emerged that continue to shape current Federal and State policy.

SOCIODEMOGRAPHIC CHARACTERISTICS AND UTILIZATION

The majority of studies on HMOs from 1973 to the present concern the Medicaid population and frequently the AFDC category alone. The populations examined are homogeneous, but not necessarily comparable to the enrollees in earlier studies. Enrolled persons were both younger and older (if the adult categories were allowed to enroll) than the average age of general HMO populations (24, 27, 63). There was also a higher proportion of adult females, again due to the preponderance of AFDC enrollees (24, 27).

The enrolled populations again had a high proportion of minority groups, reflecting the social and ethnic composition of welfare recipients. One study that compared enrollment in various types of HMOs noted that a far lower proportion of blacks enrolled in a foundation, i.e., a private practice type HMO (27). The same is true of family composition, generally larger than in the HMO population (31, 40). One study noted that adult females had higher health costs than the rest of the low-income population and general enrolled membership, due primarily to more non-physician visits (15). Still another study noted that declines in utilization

characteristics of the entire enrolled Medicaid population were far greater for adult females (24).

UTILIZATION OF SERVICES: AMBULATORY AND PREVENTIVE CARE

Use of ambulatory and preventive care by indigent persons enrolled in HMOs varies significantly from earlier studies. For the most part, utilization of physician services is the same or lower -- not higher -- than comparable Medicaid populations (24, 27).

One major study comparing ten HMOs noted that ambulatory care utilization did not differ between the enrolled and non-enrolled Medicaid populations (27). Another study found substantial reductions in the use of ambulatory services under HMO plans (24). Only one study noted higher initial rates, which then fell to the level of other HMO enrollees (60).

Two studies noted that the proportion of persons not using any health services in the sample period was the same for Medicaid enrollees and the general HMO population (15, 30). These results invite a number of interpretations. On the one hand, recipients may not have unmet health needs requiring high initial utilization of services -- and their previous source of care may have been adequate. On the other hand, such results may indicate that services are not accessible to recipients and utilization is artificially low. What they do not suggest is that ambulatory care is being substituted for inpatient services, one of the primary objectives of Medicaid-HMO contracts.

Studies reach similar findings in regard to preventive services. Utilization does not appear to vary either between Medicaid enrollees and the general enrolled population (A.4) or between enrolled and non-enrolled Medicaid populations (24). These results do not support the hypothesis that mere enrollment in an HMO will automatically lead to higher utilization of preventive services, a frequently touted advantage of prepaid health care and a finding characteristic of earlier studies. What do appear to have a major influence are outreach and education (see below).

HOSPITAL AND OTHER UTILIZATION

While few studies observed changes in using physician or ambulatory services virtually all documented a sharp drop in hospital admissions and days of care following enrollment in an HMO (24, 27, 63, 81). Utilization by Medicaid recipients was found comparable to that of the general enrolled populations. Reductions were noted regardless of the age, sex, or category of assistance involved, even when certain groups had traditionally higher incidence of hospitalization (e.g., disabled) (24).

One study also documented substantial reductions in drug utilization, not only in number, but also in type of prescription issued (24).

The reduction in inpatient utilization thus appears to be one enduring characteristic of prepaid health care.*

ACCESS, ATTITUDES, EDUCATION, AND OUTREACH

Several studies attempted to gauge members' satisfaction. Most noted that Medicaid enrollees found the HMO services as good, or better than, known sources of health care (24, 27). Some persons expressed particular satisfaction with use of paraprofessionals; others with the availability of telephone consultation.

While broken appointments, high incidence of "walk-in," and greater utilization of the emergency room consistently cropped up as disturbing elements of HMO use, recipients were integrated into health plan membership with few problems (30, 31, 35, 60, 81). Studies revealed, in one instance, that HMO physicians were entirely unaware of the source of financing for enrollees (8), and in another that some physicians were prejudiced against enrollees they knew to be Medicaid enrollees (60). Still other sutides have documented the sometimes negative perceptions of physicians toward Medicaid recipients (7).

Recent research on indigent populations traces their use of health care facilities to wider causes than just their financial status or straits (1, 17, 42): Medicaid coverage alone does not guarantee access to appropriate utilization. One study, in fact, found that education is a far more potent predictor of health status (42). Evidence cited above would confirm that enrollment in an HMO does not guarantee appropriate use of health services. Several studies conducted over the last few years centered on the impact of outreach and supportive services on HMO utilization by Medicaid recipients (13, 15, 19, 21). OEO-funded experiments had traditionally included transportation, child care, and

* Note: Only one study attempted to examine variations in utilization by type of HMO, i.e., foundation vs. group practice model (27). Most analyses (and contracts) utilize prepaid group practice plans. One study indicated that declines in hospitalization and surgery -- a prime reason for hospitalization -- were not achieved by medical foundations, although such declines are more uniformly noted by prepaid group practice plans (27). It appears that until a substantial part of the medical foundation is providing HMO care, the same incentives found in prepaid group practice are not operating in HMOs still reliant almost completely on private, fee-for-service systems.

social services in addition to covering the cost of health services. So-called neighborhood coordinators helped enrollees use the HMO or neighborhood health center. However, again, most of the initial studies focused on the need for these services since the principal objective was to encourage utilization where there had been few other sources of care. Medicaid-HMO contracts may not include such supportive services and their members have generally had some type of financial coverage of health services. So a shift to HMO services represents a move from one source of care to another and not, as in the original OEO programs, a move from very limited resources to comprehensive care.

The impact of outreach services has been uniform across all studies: enhanced use of ambulatory care and preventive services. In almost all cases, community personnel were utilized and assisted in enrollment, scheduling (and keeping) appointments, and arranging for other necessary support services (e.g., child care) (13, 15, 19, 21). Outreach also stimulated enrollment in the HMO (15) and utilization rose for even long-term enrollees (21). One study noted a particular impact on adult males, who traditionally have been underutilizers (21). Outreach further accomplished greater use of mental health and specialist services (21). It did not, however, alter the high incidence of missed appointments, unscheduled visits, and lack of follow-up visits (21). One study focused on the effect of training outreach workers in the use of preventive services. The number of immunizations, physical examinations, and Pap smears increased dramatically in the enrolled populations (13); the difference was striking even among persons enrolled in the HMO for a relatively long period of time (13). The conclusion follows that such services are generally necessary to educate indigent persons in the appropriate use of health services and reinforces findings that financial coverage -- Medicaid -- alone is insufficient to improve health status.

HEALTH STATUS

Few of the recent studies attempted to measure differences in morbidity or mortality. One failed to demonstrate any systematic difference of quality care between enrolled and non-enrolled populations, although statistically insignificant trends signaled a finding of higher quality services extended by the HMO (15). The latter finding was based on the utilization of non-physician services -- paramedical, telephone consultation -- by enrollees (15). Another study explored the motivation behind recipient enrollment, postulating poor health status as the dominant factor (27), which proved not to be the case. Whether HMO services were of uniformly higher quality remains a clouded question.

COST

As mentioned previously, most early analyses of Medicaid and low income

persons did not generally consider costs of services -- largely because information on past cost experience was unavailable. Later studies turned greater attention to this issue -- again because cost is a primary activating factor in Medicaid contracts with HMOs.

Two major results have emerged: the cost to HMOs of AFDC Medicaid recipients' participation is comparable to that of covering general HMO enrollees (A.4, 63), while substantially lower than coverage of comparable Medicaid fee-for-service populations (24). Thus, HMOs are not faced with an extraordinary overall cost burden when Medicaid enrollees are accepted, even though stort-term utilization and cost may be higher. State Medicaid programs appear to have an obvious financial incentive to utilize prepaid health services.* On the surface the cost clearly is not in excess of comparable Medicaid populations so that, other things being equal, there are not financial disincentives to contract with HMOs for services. (The next section will examine some of the administrative problems characteristic of Medicaid-HMO contracts. These have proved to be great deterrents to involvement by States.)

THE CALIFORNIA EXPERIENCE

No discussion of Medicaid-HMO contracts would be complete without a brief review of the California experience. More than in any other State (except perhaps New York), the California Medicaid (termed MediCal) program has experienced continuous and substantial growth in expenditures. In an effort to control costs, in 1971 the State adopted legislation, the MediCal Reform Act, which explicitly authorized and strongly encouraged contracts for prepaid health services. So-called prepaid health plans (PHPs) were actively promoted by the State Department of Health as cost-saving mechanisms. Contracts were solicited on an extensive basis. At its peak in 1974, the State had some 53 contracts covering nearly 300,000 enrollees. Enrollment seemed attractive to recipients largely because cutbacks in other services (e.g., limitations on physicians' visits) did not apply in PHPs. The State's rate of payment was based on fee-for-service costs less ten percent -- thus apparently guaranteeing an automatic saving for the State.

Allegations against the propriety of California's then greatly expanding program were made almost immediately at the community level, followed by widespread publicity throughout the State (76). By 1974, the State had spent $64 million, ostensibly purchasing comprehensive medical care for enrolled recipients. A flurry of reports issued by both private and

* Note: Virtually all States presently contracting with HMOs recoup cost savings accumulated under the contract's provisions.

public agencies charged abuses by PHPs ranging from poor quality care to a lack of services available to outright fraud (9, 19A, 33, 43, 56, 69, 71, 75, 80, A.15). The studies cited a veritable litany of abuses: fraudulent, deceptive enrollment practices, lack of available services as promised; lack of emergency services; poor quality services; deliberate attempts to curb utilization; unscrupulous competitive practices among PHPs in the same area, and indications of tremendous profits gleaned by providers at the expense of enrollee health needs. Alleged deficiencies in State administration were: setting of capitation rates that were not actuarially sound; inability to detect favorable or adverse selection of enrollees; no monitoring system for quality of care; insufficient monitoring of marketing procedures and enrollee grievance procedures (11, 19A, 45, 69); and insufficient staffing to provide technical assistance to PHPs. Legislation was enacted (Duffy-Waxman Act, 1973) that provided some performance standards, but for the most part, reform efforts moved slowly. The issue attracted the attention of Congress (75) and the General Accounting Office (70, 71) and fostered Federal legislation to assure that abuses did not occur in other States (see section on regulation). The California experience has overshadowed the more positive results of other State's programs, and these types of problems continue to pervade nearly ever aspect of program regulation, administration, and development, as will be observed in the following sections.

A comprehensive summary of the California PHP experience is found in the August 11, 1978, Report No. 95-1479 by the Committee on Interstate and Foreign Commerce to accompany H.R. 13655, the Health Maintenance Organization Amendments of 1978. The Report discusses PHP hearings held March 1975 and December 1976 by the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs and a subsequent report issued by the Subcommittee in April 1978. The House Report clairifies that, although the PHPs are frequently equated with HMOs, the PHPs did not conform to all of the definitional elements contained in the HMO Act, nor were they required to do so. Under the 1976 amendments to the HMO Act, PHPs would have had to meet the definitions of an HMO contained in the Federal law. One effect of the 1976 amendments was that many of the PHPs did not continue to qualify as contractors with the State of California and a high proportion of them are believed to be out of business. As of April 1978, the Report noted 13 plans still contracting with the State to provide Medicaid services, of which eight were qualified HMOs under the Federal Act.

The Department of Health, Education, and Welfare moved to address the situation in California. In 1975 the California Department of Health, still recognizing the potential advantages of PHP contracts, launched a major effort to overcome the program's deficiencies. Part of the reform strategy was development of a federally funded research and demonstration project. This project, which came to be known as the PHRED Project, was

funded in February 1976 (See reference at A.19).

PHRED developed in three major stages, as follows:

1. Rate-setting--development and demonstration of actuarial methods for establishing PHP capitation rates.

2. Quality assurance--experimental with information systems to support monitoring of quality of care in PHPs.

3. Membership studies--demonstration of marketing alternatives, and monitoring of enrollment procedures and grievance procedures used within PHPs.

Rate-Setting Demonstration

The rate-setting demonstration began in February 1976 and formally concluded in November 1977. During this demonstration the following were accomplished.

1. Revision of the PHP reporting requirement, to obtain information better suited to rate-setting needs.

2. Demonstration of actuarial methods for setting AFDC capitation rates for FY 1977-78.

3. Demonstration, and actual use by the State, of age/sex adjustment factors for FY 1977-78 rates.

4. Evaluation of the long-standing "adverse selection" hypothesis related to an HEW audit exception for Sacramento's Foundation Community Health Plan.

5. Preparation of a rate-setting guide book to be of assistance to single-state Medicaid agencies.

Although this demonstration has formally terminated, PHRED had lead responsibility for establishing PHP rates for FY 1978-79 and the PHRED method has been used as the basis for rate-setting in FY 1979-80 and for FY 1980-81.

Quality Assurance Monitoring

While the rate-setting demonstration was taking place, PHRED staff developed a proposal to demonstrate a quality assurance monitoring system, funded by HEW effective 1 December 1977. The quality assurance project has the following task areas:

1. Establishing a set of criteria for evaluating quality of care in PHPs.

2. Assessing the comparative cost-effectiveness of using an automated encounter data system and a semi-automated version of the traditional sample chart audit system to obtain information needed to apply the criteria.

3. Evaluating the feasibility of "staging" (a form of outcome-oriented health status assessment) as an administrative tool for quality-related monitoring.

4. Synthesizing and documenting the findings of these experiments.

Membership Studies

PHRED also submitted a proposal funded in June 1978, to undertake the following activities:

1. Experimentation with alternative marketing and enrollment procedures--self-enrollment by mail, information dissemination and/or enrollment in county welfare offices during eligibility determination to replace the dominant current practice of door-to-door solicitation.

2. Development of a model grievance system for PHPs, with procedures for PHPs to follow in reporting grievances to the state and for the compilation of information from disenrollment requests.

3. Development of a training program for consumers involved as PHP advisors or policy makers.

4. Improvement of survey techniques to measure satisfaction and dissatisfaction of Medicaid enrollees in PHPs and to gather enrollee opinion for state management decisions.

Policy Development

In addition to the research and demonstration activities, and proposal development described above, PHRED staff have been involved in program policy evaluation. There have been two major accomplishments in this area, as follows:

1. Policy redirection paper produced in October 1976 which reevaluated the premises of the PHP program and interpreted the significance of new federal requirements that Medicaid-contracting prepaid health organizations be federally qualified HMOs.

2. Amendments to the Welfare and Institutions Codes, commonly labled AB 1693, which strengthened the Department's regulatory authority and extended its authority for experimentation.*

SECTION V

THE ADMINISTRATION OF MEDICAID-HMO CONTRACTS**

The bulk of studies described previously inclines to focus on utilization and cost experience. Yet the administration of the contracts that has been generally left to the State Medicaid programs has also generated compelling results, some of which may outweigh (as in the California case) benefits gained from cost-savings and better utilization. The following is a summary of the areas creating some of the greatest administrative difficulties for both States and HMOs.***

ENROLLMENT: MARKETING AND EDUCATION

One of the most problematic aspects of HMO operations is marketing and enrollment. Prospective members must be apprised of the differences between prepaid health care and the more traditional fee-for-service system and be able to recognize the constraints of one versus the other. Lack of knowledge and understanding hampers the HMO's marketing ability. This problem is tremendously compounded for low income persons. Only recently have more Medicaid recipients understood the program's benefits. For many years, caseworkers unfamiliar with Medicaid could not adquately inform recipients of its advantages. Nor were the poor sufficiently knowledgeable about the fee-for-service system to make informed decisions about available alternatives. This lack of knowledge on the part of recipients has made marketing by HMOs extremely difficult.

Other features of the Medicaid program constrain marketing and enrollment, e.g., confidentiality provisions prohibit the release of recipient names forcing some HMOs to canvass neighborhoods with a known high concentration of Medicaid eligibles. This is expensive and inefficient. On the other

* The written materials developed over the more than four years of the Projects' existence are identified at the end of the bibliography.

** Much of the information in this section is derived from interviews with States.

*** Few studies have focused on these areas unless certain abusive practices have emerged (i.e., California). HHS has, however, published some manuals and guidelines relating to these areas.

hand, the State is unable to promote HMO enrollment (through a mailing, for example) because of freedom of choice gaurantees. Under the statutory requirements for Medicaid, a recipient has the freedom to choose any health provider willing to accept Medicaid. The State cannot, therefore, ever appear to recommend one provider, such as an HMO, over another. Thus, it is frequently unable to educate recipients about the advantages or disadvantages of prepaid health care and must leave enrollment outreach to the HMO (an activity that is extremely difficult to monitor). Recently the California PHRED Project has been evaluating the use of county social service employees to explain HMO availability.

These problems -- lack of consumer knowledge and freedom of choice -- are less pressing if the HMO is an established, well-known source of health services. Here the community reputation may be such that enrollment is highly desirable. For many HMOs, however, Medicaid is an initial source of membership whose actual enrollment remains extremely complex and expensive.

TURNOVER AND ELIGIBILITY

Another problem which plagues Medicaid-HMO contracts is turnover of the enrolled population. This shifting of the Medicaid membership occurs for essentially two reasons: voluntary disenrollment from the plan or loss of Medicaid eligibility (resulting in loss of Medicaid benefits).

The freedom of choice provisions require that recipients voluntarily enroll or disenroll in HMOs. Partly because of these provisions, most States do not require minimum periods of enrollment. A recipient may enroll one month and may leave the program the next. This flexibility creates administrative problems for both the State and the HMO. The State, for example, must assure that the recipient has continuous Medicaid coverage -- whether services are supplied by the HMO or other sources. A recipient must have either an HMO card or Medicaid card. The timely issuance of each is complex and requires constant communication between the State and the HMO. States naturally wish to avoid out-of-plan utilization that means paying for services twice, but that is only possible if both HMO and Medicaid cards are issued. Still, they must assure that the recipient receives only one card, a cumbersome task if enrolled turnover is great. The problem is equally great for the HMO; it is unable to project membership size and hence revenues accurately. In addition, it must constantly inform the State regarding enrollment and disenrollment of Medicaid recipients -- a costly and time-consuming burden.

Loss of Medicaid eligibility constitutes involuntary disenrollment for an HMO.* The State alone has the authority to institute disenrollment in this instance. As long as Medicaid is a means or income-tested program, eligibility is not guaranteed. AFDC rolls fluctuate a great deal; HMO enrollment shifts to reflect those changes.

There is a strong inherent relationship between enrollee turnover and marketing and client education. Several States have noted that recipients were not adequately informed about the nature of HMO operations, e.g., the use of one facility or physician group. In particular, recipients do not understand that HMO enrollment replaces the monthly Medicaid card and more familiar sources for care. Their lack of orientation acts as a barrier so that enrollees may never sample plan services, but rather decide to withdraw before gaining any actual experience. The problem can be partially ameliorated with informed and effective marketing, recipient education and, where necessary, outreach services.

PREMIUM DEVELOPMENT

Developing appropriate prepaid capitation payments poses a difficult problem in drawing up Medicaid-HMO contracts. Most States negotiate a range of premiums that largely depend on the category of public assistance. A common practice has been to pay the HMO the average cost per recipient based on fee-for-service experience. Some States may discount that amount by a certain percentage to reflect the projected cost-saving generated by the HMO (California originally paid ten percent below fee-for-service). However, increasingly States have come to recognize that the lack of comparability between the HMO's mix of services and substantial reductions in hospital utilization is not reflected in fee-for-service comparisons. Then, too, the HMO population may vary significantly from the entire Medicaid population (upon which fee-for-service estimates are based.) Age, family composition, and sex--all important determinants of utilization and cost -- are particularly subject to such variations. The differences have major implications for the cost of services actually incurred by the HMO for which the State should be paying.

* Several initial experiements with Medicaid-HMO contracts waived periodic eligibility determinations for enrolled recipients (notably 24), some up to three years. Thus, there was a strong incentive for recipients to maintain enrollment, rather than risk losing Medicaid altogether. Such waivers are no longer available.

REGULATIONS AND QUALITY ASSURANCE: CERTIFICATION, LICENSURE, AND MONITORING

The California MediCal experience with prepaid health plans graphically portrayed the need to monitor the quality of services financed by Medicaid-HMO contracts. A State has two options in this regard: regulation through licensure -- generally accomplished through the State Department of Health -- and/or insurance or regulation through the Medicaid-HMO contract. In the latter option, the State prescribes standards in the contract that, if complied with, would theoretically assure quality services for all enrollees. Some States utilize both mechanisms and three State departments -- health, welfare, and insurance.

Monitoring HMO performance consists of two basic activities: periodic on-site evaluation of services and continuous monitoring of reports and statistics. Under a capitation program, Medicaid remits periodic payment for all services. Fee-for-service billing is eliminated -- one of the advantages of HMO contracts. However, most States compile the information gathered from claims to monitor utilization and quality. Without it, the State must rely on data collected by the HMO to assure appropriate utilization of services, but collection of timely and comprehensive information from HMOs has been a problem in several States. Few have received enough information to adequately assess HMO performance. Because of the lack of claims under the system, comparison of HMO to fee-for-service populations has also proved difficult. It is this question -- appropriate methods of monitoring HMO performance, assuring that services are rendered in proportion to the premium paid -- that sometimes prevents States from contracting with HMOs.* States accustomed to dealing only with individual provider claims need assistance about how to evaluate aggregate cost and utilization data for a defined population.

INVOLVEMENT OF LOCAL AGENCIES

The least explored area in Medicaid-HMO contracts is the role of local

* It is interesting to note, however, that HMOs have come under more intense scrutiny than other Medicaid providers in many ways. The States' concern is far out of proportion to its number of enrollees and cost relative to the entire Medicaid population.

  It appears that States are more willing to devote resources to monitoring payments made on a prepaid basis than to those where specific claims are made. Given recent allegations of fraud and abuse by individual Medicaid practitioners, it seems far more profitable to pursue review of other providers.

welfare agencies. Although county welfare department represent the first contact the recipient has with Medicaid, for the most part, county involvement in HMOs has been severely limited. Some States require local agencies to verify HMO enrollment once it has occurred (they contact the recipient directly), but little else. In terms of enrollment, education, and particularly outreach, county agencies have tremendous potential to influence development and growth of HMO-Medicaid contracts, but expansion of such contracts can only occur if local agencies play a more active role. Experiments in California have been mentioned previously. The Portland, Oregon "Project Health" also uses neutral persons to explain the mutiple health options available to low-income eligible persons.

SECTION VI

REGULATION OF HMOS: THE IMPACT ON MEDICAID-HMO CONTRACTS

Until relatively recently, many States had not enacted statutes specifically aimed at developing HMOs. (At present 36 States have adopted enabling legislation.) Thus, to a great extent, State Medicaid programs did not have a clear option to contract for prepaid health services. Initially, those States that pursued contracts did so on an experimental basis, frequently funded by the Federal Government. These first efforts saw little involvement of either State of Federal regulatory agencies -- for the most part, States were free to negotiate with HMOs independent of Federal guidelines. The situation has changed radically. Recent Federal legislation has dramatically altered the development and regulation of HMOs and several Federal agencies have become involved in HMO regulation. Virtually all of these entities affect Medicaid contracts.

Similar diversification occurs at the State level. Traditionally, HMOs have been regulated by insurance departments, largely because HMOs are deemed to offer a form of health insurance. More recently, State health agencies have become involved in a certification of licensure. And again, State welfare departments may exercise considerable authority through Medicaid contracts. Following is a brief discussion of Federal and State regulations and their impact on Medicaid.

DHEW: THE MEDICAL SERVICES ADMINISTRATION

Until a 1977 DHEW reorganization, the Medical Services Administration (MSA), within the Social and Rehabilitative Services, was the Federal agency responsible for administration of Medicaid. Throughout Medicaid's ten-year history, prepaid health care received intermittent attention while the agency also funded various experiments with the States to gauge the feasibility and effectiveness of contracts between Medicaid and HMOs. During that period, States were fairly free to function on their own. No

guidelines were published and technical assistance, generally provided by the DHEW Regional Offices, was limited. The agency was however, interested in encouraging States to at least explore contracting possibilities. A training conference, jointly sponsored by MSA and the HMO service, was held in November 1973, to provide States with some basic information and assistance (73).

In 1974, Federal interest in Medicaid-HMO contracts was heightened by the flood of reports on the California PHP programs. The General Accounting Office particularly cited the lack of Federal monitoring and control of California contracts, half of whose costs had been borne by DHEW (70, 71). As a result, MSA published draft regulations in 1974 setting standards for any Medicaid contracts for the provision or financing of health services. Final regulations were published in May 1975 (45 CFR 249.82) that specified broad guidelines under which State contracts would be approved. The original mission of the California Prepaid Demonstration Project was to develop and demonstrate administrative procedures and information systems which would enable California and other States to comply with these regulations. Requirements for prepaid health plans specifically spelled out limitations on the proportion of Medicaid (and Medicare) recipients in the entire plan; requirements in the minimum period of enrollment as to preclude rapid turnover; specifications on disenrollment policy; guarantees on availability and accessibility of services; provisions for prompt payment for services by the State, for enrollee grievance mechanisms, for internal quality assurance mechanisms, for adequate health education and approved marketing plans, and for a variety of devices to assure the financial capability and stability of the prepaid contractor. In short, the requirements are designed to avoid many of the problems characteristic of the early California PHP experience. All contracts are now subject to approval by the Regional DHHS offices prior to implementation.

In 1977 Medicare and Medicaid were consolidated into the Health Care Financing Administration (HCFA) and in 1980 DHEW became the Department of Health and Human Services.

Beyond the regulations, HCFA has sponsored training seminars to assist States in negotiating contracts (74). Most States have not been hampered by the Federal regulations since their own guidelines and standards often are more stingent and exacting, particularly in those States that license HMOs. Again, it is interesting to note that virtually no other Medicaid provider of ambulatory care is subject to such intense review.

DHEW: SOCIAL SECURITY ADMINISTRATION

Prior to March 1977, the Social Security Administration was responsible for Medicare, the Federally managed program of health insurance for

persons over 65 years of age. While not directly related to Medicaid until the recent creation of the Health Care Financing Administration, the Medicare program has had a distinct influence on Medicaid. Many Federal Medicaid policies are similar or identical to Medicare despite the basic differences in the two programs. Therefore, Medicare policy on enrollment of eligible persons in HMOs affected Medicaid policy. Most noteworthy was Medicare's failure to pursue contracts with HMOs prior to 1977. Final regulations governing Medicare involvement in HMOs were published in 1975 and 1976, three years after enactment of the enabling legislation for HMO contracts. This seeming reluctance to issue guidelines stalled Medicaid policy development. However, since many Medicare recipients are also Medicaid eligibles, some researchers have looked at Medicare enrollment in HMOs. There are 50 Medicare reimbursement contracts in effect as of December, 1980. More Medicare contracts with HMOs are being pursued by HCFA actively.

HHS: THE PUBLIC HEALTH SERVICE

P.L. 93-222, the Health Maintenance Organization Act of 1973, and the implementing regulations published October 18, 1974, contained important special requirements of HMOs that enrolled members entitled to Medicaid assistance.

Section 1307(d) of the Act and Subpart A, Section 110.110 of the regulations, provided for an HMO to be considered qualified under the Act if, for non-Medicare and Medicaid members, the HMO met the Act's requirements, and for Social Security Act members if it complied with five special requirements: 1) providing, at a minimum, only services covered under the contract with a State, and not requiring Medicaid eligibles to obtain coverage for services not included in either the contract or the Title XIX State plan; 2) payment for services under the Title XIX State plan did not have to be based on a community rating; 3) the HMO had to assume full financial risk only as required under the contract with the State and not as specified in Section 1301 of the Act; 4) payments for services not covered by the contract with the State could be fixed in a variety of ways; and 5) the HMO complied with applicable reimbursement provisions authorized under the State plan.

Responsibilities for administering these provisions were shared among the Medical Services Administration, the Social Security Administration, and the Health Services Administration, particularly the Office of HMO Qualification and Compliance. That office had responsibility for determining that the applicant for HMO qualification under P.L. 93-222 had complied with the Act's requirements, as well as applicable Medicare and Medicaid requirements.

Agency coordination was accomplished by a work group that cooperated to develop regulations and policies governing relationships between qualified HMOs and designated governmental components.

On October 9, 1976, P.L. 94-460 was signed. It amended the HMO Act of 1973 in several major ways, one of which involved prepaid contracts with HMOs under Medicaid.

Section 202 of P.L. 94-460 amends Title XIX and provides a definition of an HMO (in Medicaid) that relies, by cross reference, upon the definition of an HMO in Section 1301 of the HMO Act, except to specify that for purposes of Title XIX:

-- Basic health services means the following mandatory Medicaid services: inpatient hospital services, outpatient hospital services, other laboratory and x-ray services, family planning services, physicians' services, and home health services.

-- The amendment also provides that an HMO under Title XIX may have no more than half of its enrollees either covered under Medicare or receiving Medicaid. The Secretary may waive this requirement for up to three years if the organization demonstrates that it is making progress toward meeting the requirement. For additional explanation of this provision, see the Federal Register Notice of March 22, 1977, pages 15472 and 15473.

The amendment further requires the Secretary to determine, through the Assistant Secretary for Health, whether an organization is an HMO within the meaning of the new definition in Medicaid and in an integrated fashion with Sections 1312(a) and (b) of the HMO Act (concerning continued regulation of HMOs). The amendment allows a State to make a provisional determination for purposes of its Medicaid program that an organization is an HMO where (1) the organization has applied to the Secretary to become a qualified HMO under Section 1310(d) of the Public Health Service Act and (2) no determination has been made within 90 days. The State's provisional decision remains in effect until the Secretary makes a determination.

Lastly, the amendment eliminates Federal matching funds under Title XIX for State expenditures for services of an organization that provides on a prepaid capitation, at-risk basis inpatient hospital services and any other mandated Medicaid service, or any three other Medicaid services, unless the organization either:

1. has qualified as an HMO; or

2. has received a grant as a community health center or a migrant

health center of $100,000 or more in fiscal year 1976 and a similar grant in subsequent fiscal years; and

3. provides on a prepaid capitation, at-risk basis inpatient and outpatient hospital services, laboratory and x-ray services, family planning services, and physicians' services.

Two exceptions to this requirement are:

1. It will not apply to a nonprofit primary health care entity, located in a rural area, that received a grant, subgrant, or subcontract of $100,000 or greater under the Appalachain Regional Development Act in fiscal year 1976, and in each year therafter either continued to receive such grant or provided services under contract on a risk basis for Title XIX recipients.

2. Nor will it apply to an organization that has contracted for the provision of services (not including inpatient hospital services) to persons eligible under Title XIX on a prepaid risk basis prior to 1970.

Congress passed the amendment because of the perceived need for increased Federal oversight of arrangements under Title XIX for services provided on prepaid risk basis. The Conference Report (94-1513) states a concern, however, that the provision should not preclude primary health care organizations receiving funds from the Appalachian Regional Commission; from serving Medicaid recipients on a risk basis; or prevent their continuing risk contracts with organizations, such as the Health Insurance Plan in New York City, which have had a long-standing contractual relationship to provide services to Medicaid recipients on a prepaid risk basis.

On October 4, 1979, P.L. 96-79 was signed. The law amended Section 1903(m)(2)(C) of the Social Security Act. The amendment modified the time period in which a qualified HMO has to meet the Medicare/Medicaid enrollment mix (Section 1903(m)(2)(A)(II)) by specifying that the date of qualification starts the three year period. The most current Medicaid regulations covering contracting with HMOs and Prepaid Health Plans are in the Federal Register, October 1, 1979, part 400.

SECTION VII

MEDICAID AND THE DEVELOPMENT OF HMOS

The inclusion of Medicaid beneficiaries in HMOs was a fundamental part of the HMO strategy formulated by DHEW in 1970. It was understood that HMOs

were to serve a cross-section of their communities. To facilitate these objectives, various legislative amendments to the Social Security Act were proposed between 1970 and 1973 to enable or to clarify the basis for Medicare and Medicaid programs entering into prepaid capitation contracts with HMOs for comprehensive health services.

DHEW attempted to shape three major components of the Medicaid-HMO involvement in the 1970-1973 period before enactment of P.L. 93-222. First was the intent to influence policy determination at all levels of government as the HMO initiative developed, to ensure that the interests of the poor were adequately addressed and that they were served through a single class of health services fashioned for all elements of the population without creating a separate health system for the poor.

Second was the need to coordinate with other agencies' resource development activities so that developing HMOs were willing and able to enroll Medicaid recipients. This coordination of resource development was seen as a two-way street: developing an HMO's capacity to enroll Medicaid recipients means expanded resources for the program, and Medicaid's reimbursement potential can be an important source of working capital for operating HMOs.

Third was the recognition of the need to assist States in developing their capacity to negotiate HMO-Medicaid contracts to enroll Medicaid recipients. This function was given greater emphasis by Congress when it added Section 1903(k) through the passage of Section 226(e) of P.L. 92-603.

In early 1971, DHEW could identify ten organizations that had entered into prepaid capitation contracts under Medicaid with seven different States covering approximately 135,000 Medicaid recipients.

In 1973, DHEW identified 62 organizations that held such contracts with 12 different States covering 200,070 Medicaid recipients. Current DHHS data shows 16 States have contracts with 37 organizations covering 193,379 Medicaid recipients.

During the 1971-1973 period, when various HMO legislative proposals were being considered, there was Senate support for provisions to subsidize or underwrite premiums for enrollees who could not afford to pay. This provision was dropped during final deliberations. However, P.L. 93-222 did contain several references to a "medically underserved population." It specified priorities to be given to HMO applicants for financial assistance under the Act who intended that not less than 30 percent of

their members come from a medically underserved population.* The only population readily definable as medically underserved and for whom there is a source of payment is, of course, Medicaid recipients. Therefore, the pre-HMO Act efforts to include Medicaid in the overall HMO program have been sustained through a combination of circumstances including the legislative mandates of the HMO Act.

There are many more organizations referred to as HMOs than are designated as qualified by DHHS. Many of the non-qualified organizations either have, or have attempted to obtain prepaid Medicaid contracts. A review of the Community Health Network Program (52), revealed two major hurdles to developing Medicaid contracts: 1) the relative unfamiliarity of Medicaid administrative personnel with prepaid capitated contracts, and 2) a reluctance of some States to contract with organizations having a proverty image.

While qualified HMOs do not have the poverty image to overcome, they have reported problems similar to those encountered by the Networks: educating Medicaid administrators, identification of Medicaid recipients for marketing purposes, frequent eligibility recertification, requirements that the recipient relinquish his Medicaid card, and the limiting of the recipient to a single provider of care.

* This provision was designed to avoid a problem that has risen in several States -- organizations which serve only Medicaid populations. So-called "Medicaid-only" HMOs are entirely dependent on State revenues for existence and are not economically viable without them. In addition, these organizations have repeatedly been cited for providing poor quality medical care, a characteristic largely attributable to the fact that State monitoring is poor; with no members other than Medicaid recipients, the scrutiny and evaluation of other insured groups is absent. Most States generally avoid contracts with prepaid organizations wishing to serve Medicaid beneficiaries only.

BIBLIOGRAPHY

1. Aday, Lu Ann, "The Impact of Health Policy on Access to Medical Care," Milbank Memorial Fund Quarterly, Vol. 54:2, Spring 1976 (pp. 215-230).

2. Alpert, J., J. Kosa, and R. Haggerty, "A Month of Illness and Health Care Among Low Income Families," Public Health Reports, Vol. 82:8, August 1967.

3. Andersen, R., A Behavioral Model of Families' Use of Health Services, (University of Chicago Center for Health Administration Studies: Chicago 1968).

4. Bellin, S., and J. Geiger, "Actual Public Acceptance of Neighborhood Centers," Journal of the American Medical Association Vol. 214, December 21, 1970.

5. Bellin, S., and J. Geiger, "Impact of a Neighborhood Health Center on Patients' Behavior and Attitudes Relating to Health Care," Medical Care, Vol. 10:3, 1972.

6. Birnbaum, R.W., Guidelines for the Planning of, or Conversion to, a Health Maintenance Organization, (Office of Health Affairs, OEO/DHEW: Washington, D.C., 1972).

7. Brian, E., and S. Gibbons, "Medi-Cal Patients: How Do Physicians Compare Them With Other Patients?", Medical Care, Vol. 12:11 (November 1974), pp. 918-927.

8. Broida, J.H., and M. Lerner, "Knowledge of Patients' Method of Payment by Physicians in a Group Practice," Public Health Reports, Vol. 90:2 (March-April 1975), pp. 113-118.

9. California Council for Health Plan Alternatives, Report to Health and Welfare Committee of International Brotherhood of Teamsters (Los Angeles 1974).

10. California Joint Legislative Audit Committee, Report of California Department of Health Prepaid Health Plans (California Auditor General: Sacramento, April 22, 1974).

11. California State Department of Health, A Review of the Regulation of Prepaid Health Plans, 1974.

12. Coburn, A.S., "Health Maintenance Organizations: Implications for Public Assistance Recipients," Public Welfare, Vol. 31:2 (Spring 1973), pp. 28-33.

13. Colombo, T.J., D.K. Freeborn, J.P. Mollooly, and V.R. Burnham, "The Effect of Outreach Worker's Education Efforts on Use of Preventive Services by a Poverty Population," American Public Health Association Annual Meeting, Miami (November 1976).

14. Colombo, T.J., E.W. Saward, and M.R. Greenlick, "The Integration of an OEO Health Program Into a Prepaid Comprehensive Group Practice Plan," American Journal of Public Health, April 1969, pp. 641-650.

15. Coltin, C., R. Neisuler, and R.S. Luria, Evaluation of a Program to Facilitate the Integration of a Low Income Population Into a Prepaid Group Practice Plan, (Harvard Community Health Plan: Cambridge, July 1976).

16. Daily, E.F., "The Health Insurance Plan - New York City Welfare Department Project," American Journal of Public Health, Vol. 53:9 (September 1963).

17. Davis, K., and R. Reynolds, "The Impact of Medicare and Medicaid on Access to Medical Care," in R. Rosett (ed.), The Role of Health Insurance in the Health Services Sector, (National Bureau of Economic Research, New York, 1976), pp. 391-425.

18. Densen, P.M., E.W. Jones, E. Balamuth, and S. Shapiro, "Prepaid Medical Care and Hospital Utilization in a Dual Choice Situation," American Journal of Public Health, Vol. 50:11 (November 1960).

19. Diehr, P., K. Jackson, and M.V. Boscha, "Access to Medical Care: The Impact of Outreach Services on Enrollees in a Prepaid Health Insurance Program," Health and Social Behavior, Vol. 16:3 (September 1975), pp. 326-340.

19A. D'Onofrio, C., and P. Mullen, "Consumer Problems With Prepaid Health Plans in California: Implications for Serving Medicaid Recipients in Health Maintenance Organizations," Public Health Reports, Vol. 92, No. 2 (March-April, 1977), pp. 121-134.

20. Drucker, W., "Progress Report on Utilization of Medical Care Services by Project Enrollees from February 1971 through February 1972," unpublished report to Seattle Community Health Board, March 20, 1973.

20A. Feldman, J.J., E.J. Salber, and H. Johnson, "The Effect of Residential Mobility on Registration Rates of a Population Served by a Neighborhood Health Center," HSMHA Health Reports, Vol. 86, September 1971.

21. Freeborn, D.K., J.P. Mullooly, T. Colombo, and V. Burnham, The Effect of Outreach Wrokers on Medical Care Utilization for a Poverty Population, (Kaiser Foundation Hospitals Health Services Research Center: Portland 1976).

22. Freeborn D.K., C.R. Pope, M. Davis, J. Mullooly, "Health Services, Socioeconomic Status and Utilization of Outpatient Services for Members of a Prepaid Group Practice," American Public Health Association Annual Meeting, New Orleans, October 1974.

23. Friedson, E., Patients' Views of Medical Practice: A Study of Subscribers to a Prepaid Medical Care Plan in the Bronx (Russell Sage Foundation: New York 1961).

24. Fuller, N., and M. Patera, Report on a Study of Medicaid Utilization of Services in a Prepaid Group Practice Plan (USDHEW/SRS: Washington, D.C., January 1976).

25. Gartside, F.E., "The Utilization and Costs of Services in the San Joaquin Prepayment Project," Report #2 in Medicaid Services in California Under Different Organizational Modes, School of Public Health, University of California, Los Angeles, January 1971.

26. Gartside, F.E., and D.M. Procter, "Physician Participation in the San Joaquin Prepayment Project," Report #1 in Medicaid Services in California Under Different Organizational Modes, School of Public Health, University of California, Los Angeles, January 1970.

27. Gaus, C., B. Cooper, and C. Hirschman, "Contrasts in HMO and Fee-for-Service Performance," Social Security Bulletin, Vol. 39:5 (May 1976), pp. 3-14.

28. Gaus, C.R., N.A. Fuller, and C. Bohannon, "HMO Evaluation: Utilization Before and After Enrollment," American Public Health Association Annual Meeting, Atlantic City, New Jersey, November 1972.

29. Goldensohn, S.S., et al, "Referral, Utilization and Staffing Patterns of a Mental Health Service in a Prepaid Group Practice Program in New York," American Journal of Psychiatry, Vol. 126:5, 1969.

30. Greenlick, M.R., "Medical Service to Poverty Groups" in A. Somers (ed.) The Kaiser Permanente Medical Program - A Symposium (Commonwealth Fund: New York, 1971), pp. 138-148.

31. Greenlick, M.R., D. Freeborn, T. Colombo, J. Prussin, and E. Saward, "Comparing the Use of Medical Care Services by Medically Indigent and a General Membership Population in a Comprehensive Prepaid Group Practice Program," Medical Care, Vol. 10, pp. 187-200.

32. Greenlick, M.R., A.V. Hurtado, C.R. Pope, E. Saward, and S.S. Yoskiska, "Determinants of Medical Care Utilization," Health Services Research, Winter 1968, pp. 296-315.

33. Greenwald, S., "Attitudes and Experiences of MediCal Beneficiaries Under Consolidated Medical Systems Ltd.," (National Health Law Project: Los Angeles, 1974).

34. Group Health Cooperative - Puget Sound, "Accessibility of Group Health Care to Aid to Dependent Children Recipients," GHC Research Note #6, July 28, 1970.

35. _____, "Non-Appearance of Appointed Enrollees for Care Among Public Assistance Enrollees for Comprehensive Prepaid Medical Care," GHC Research Note #9, 1970.

36. _____, "Utilization of Comprehensive Medical Services by Public Assistance Patients During the First Six Months of Enrollment in a Prepaid Group Practice," GHC Research Note #10, January 15, 1971.

37. Harper, D., "Providing Health Care to the Poor," New York State Journal of Medicine, Vol. 69, July 15, 1969.

38. Hester, J., and E. Sussman, "Medicaid Prepayment: Concept and Implementation," Milbank Memorial Fund Quarterly, Fall 1974, pp. 415-444.

39. Kaiser Foundation Health Plan, "A Comparison of the Demographic and Utilization Characteristics of the Comprehensive Health Services Project Population with the Kaiser Foundation Health Plan Membership, January 1972 - December 1972," Kaiser Foundation, Oakland, California, 1973.

40. Kidneigh, J.D., "Health Care for the Poor: A Study of the Patterns of Use and Cost Factors in Two Group Practice Prepayment Plans," Group Health Plan, Inc., January 31, 1973.

41. Kisch, A.I., and F.E. Gartside, "Use of a County Hospital Outpatient Department by Medi-Cal Recipients," Medical Care, Vol. 6:6 (November-December 1968).

42. Lefcowitz, M.J., "Poverty and Health: A Reexamination," Inquiry, Vol. 10:1, March 1973, pp. 3-13.

43. Leyhe, D.L., F.E. Gartside, and D.M. Procter, "Medi-Cal Patient Satisfaction Under an OEO Neighborhood Health Center in South Central Los Angeles," in Medicaid Services in California Under Different Organizational Modes, Report #4, School of Public Health, University of California, Los Angeles, March 1972.

44. Leyhe, D.L., and D.M. Procter, "Medi-Cal Patient Satisfaction Under a Prepaid Group Practice and Individual Fee-for-Service Practice," Report #3, in Medicaid Services in California Under Different Organizational Modes, School of Public Health, University of California, Los Angeles, June 1971.

45. Louis, D., and J.J. McCord, Evaluation of California's Prepaid Health Plans, General Research Corporation, Santa Barbara, September 1974.

46. Martin E. Segal Company, HMOs and Medicaid: Approaches to Capitation Contracting. Report to the Division of Health Maintenance Organizations, HSM 110-72-36, New York 1977.

47. McClure, W., "Financing Barriers to HMO Care: Problems and Approaches," Mimeographed Speech.

48. Morehead, M., R. Donaldson, and M. Servalli, "Comparisons Between OEO Neighborhood Health Centers and Other Health Care Providers." American Journal of Public Health, Vol. 61:7, July 1971.

49. Myers, B., "Prepaid Contracts: One State's Motivation," delivered at Workshop for Title XIX Program Directors on HMO Contracting-Verbatim Proceedings, October 1-2, 1974, St. Louis, Missouri.

50. Newman, H.F., "The Impact of Medicare on Group Practice Prepayment Plans," American Journal of Public Health, Vol. 59:4, April 1969, pp. 629-634.

51. Olendzki, M.C., "Effect of Medicaid on Choice of Medical Facility," in Speigel, Podair (eds.), Medicaid: Lessons for National Health Insurance Aspen Publications, Washington, 1974.

52. Penchansky, R., and S. Berki, "Determinants of HMO Development: Lessons from the Community Health Program," American Public Health Association, Miami, November 1976.

53. Richardson, W.C., "The Seattle Prepaid Health Care Project: Comparison of Health Services Delivery," School of Public and Community Medicine, University of Washington, Seattle, 1977.

54. Rosenthal, J., J. Posner, and W. Folsom, "Optometric Prescribing Patterns: A Quality Comparison of Medicaid and Non-Medicaid Practitioners," Medical Care, Vol. 13:6, June, 1976, pp. 499-510.

55. Salkever, D., P.S. German, S. Shapiro, R. Horley, and E. Skinner, "Episodes of Illness and Access to Ambulatory Care in the Inner City: A Comparison of HMO and Non-HMO Populations," Health Services Research Center, Johns Hopkins University, Baltimore, 1976.

56. Schneider, A., and J.B. Stern, "Health Maintenance Organizations and the Poor: Prospects and Problems," Northwestern University Law Review, Bol. 70:1, January, 1975, pp. 90-138.

57. Schumaker, C.J., "Change of Health Center Sponsorship: Impact of Patterns of Obtaining Medical Care," American Journal of Public Health, Vol. 6:8, August, 1971.

58. Shapiro, S., and J. Brindle, "Serving Medicaid Eligibles," American Journal of Public Health, April, 1969, pp. 635-641.

59. Shapiro, S., J. Williams, A. Yerby, P. Densen, and H. Rosner, "Patterns of Medical Use by the Indigent Aged Under Two Systems of Medical Care," American Journal of Public Health, Vol. 57:5, May, 1967, pp. 784-790.

60. Shragg, H., M. Fagenbaum, J.W. Kovner, J.M. Caro, and E.D. Bunting, "Low Income Families in a Large Scale Prepaid Group Practice," Inquiry, Vol. 10:2, June, 1973, pp. 52-60.

61. Skinner, E.A., P.S. German, and A.G. Zauber, "Use of Ambulatory Health Services by the Near Poor," American Public Health Association, Miami, October 16-20, 1976.

62. Solon, J.A., "Changing Patterns of Obtaining Medical Care in a Public Housing Community: Impact of a Service Program," American Journal of Public Health, Vol. 57:5, May, 1967.

63. Sparer, B., and A. Anderson, "Utilization and Cost Experience of Low-Income Families in Four Group Practice Plans," New England Journal of Medicine, Vol. 89, July 12, 1973, pp. 67-72.

64. Sparer, G., G.B. Dines, and D. Smith, "Consumer Participation in OEO-Assisted Neighborhood Health Centers," American Journal of Public Health, Vol. 60:6, June, 1970.

65. Sparer, G., and L.M. Okada, "Welfare and Medicaid Coverage of the Poor and Near Poor in Low-Income Areas," HSMHA Reports, Vol. 86:12, December, 1971, pp. 1099-1106.

66. Strauss, M.A., and G. Sparer, "Basic Utilization Experience of OEO Comprehensive Health Services Projects," Inquiry, Vol. 3:4, pp. 162-178.

67. Stuart, B., "Equity and Medicaid," The Journal of Human Resources, Vol. 7, No. 2, pp. 162-178.

68. Trussell, R.E., M. Morehead, et al, "The Quantity, Quality and Costs of Medical and Hospital Care Secured by a Sample of Teamster Families in the New York Area," New York, 1962.

69. U.S. General Accounting Office, "Deficiencies in Determining Payments to Prepaid Practice Plans Under California's Medicaid Program," Report to the Senate Finance Committee (MWD-76-15), August 29, 1975.

70. _____, "Effectiveness of Grant Programs Aimed at Developing Health Maintenance Organizations and Community Health Networks," Report to Congress (MWD-75-98), November 21, 1975.

71. _____, "Better Controls Needed for Health Maintenance Organizations in California," Report to the Senate Finance Committee, September 10, 1974.

72. _____, "Outpatient Health Care in Inner Cities: Its Users, Services, and Problems," Report to Congress (MWD-75-31), June 6, 1975.

73. SRS/BCHS, "Proceedings of National Conference for Developing Title XIX - HMO Contracts," September 18-20, 1973, Miami, Florida.

74. _____, SRS, "Workshop for Title XIX Program Directors on HMO Contracting-Verbatim Proceedings, "October 1-2, 1974, St. Louis, Missouri.

75. U.S. Senate, "Prepaid Health Plans," Hearings Before Permanent Subcommittee on Investigations , Committee on Government Operations, March 13-14, 1975.

76. Van Steenwyk, J., "Actuarial Adventures on the Health Care Frontier," presented at National Blue Cross/Blue Shield Actuarial Statistical Research Conference, Chicago, Illinois, November 12, 1973.

76A. Van Steenwyk, J., Report to California State Department of Health Concerning Methods of Reimbursement to Prepaid Health Plans (1974).

77. Wartzen, J., et al, "HMOs: A Critical Appraisal of the Harvard Community Health Plan," Harvard Medical Alumni Bulletin, September-October, pp. 12-21.

78. Weinerman, F.R., "Patients' Perceptions of Group Medical Care," American Journal of Public Health, Vol. 54:6, June, 1964, pp. 880-888.

79. West, J., "Group Practice Prepayment Plans in the Medicare Program," American Journal of Public Health, Vol. 59:4, April, 1969, pp. 624-629.

80. Whitaker, I., "Prepaid Health Plans - The California Experience," in Prepaid Health Plans, Hearings Before Permanent Subcommittee on Investigations, Committee on Government Operations, U.S. Senate, March 13-14, 1975.

81. Worth, R.M., "A Comparison of Fee-for-Service and Capitation Medicine in a Low Income Group In Honolulu," Hawaii Medical Journal, Vol. 33:3, March, 1974, pp. 91-96.

ADDITIONAL CITATIONS

A1. Bartlett, Lawrence, "HMOs and the Poor," Public Welfare, Vol. 37:2, Spring, 1979, pp. 50-53.

A2. Bice, Thomas, "Risk Vulnerability and Enrollment in a Prepaid Group Practice," Medical Care, Vol. 13:8, August 1975, pp. 698-703

A3. Bosch, Samuel, J.; Rolando Merino; Marionette S. Daniels; Ellen Fisher and Murray Rosenthal, "A Proposed Network to Improve Access to High Quality Health Care for Medicaid Eligible Families," Journal of Community Health, Vol. 4:4, Summer, 1979, pp. 302-311.

A4. Coltin, Kathy; Ross Neisuler and Robert S. Lurie, "Utilization of Preventive Services by Poor, Near-Poor and Non-Poor Members of an HMO," Presented at APHA Annual Meeting, October 1978, Los Angeles.

A5. Fuller, Norman, Margaret Patera and Krista Koziol, "Medicaid Utilization of Services in a Prepaid Group Practice Plan," Medical Care, Vol. 15:9, September 1977, pp. 705-737.

A6. Heller, D. Brian, "HMOs and Medicaid," Proceedings of the 28th Annual Group Health Institute, New York, June 1978 (Group Health Association of America: District of Columbia), pp. 149-153.

A7. Johnson, Richard G., and Daniel Azevedo, "Comparing the Medical Utilization and Expenditures of Low Income Health Plan Enrollees Medicaid Recipients and Low Income Enrollees Having Medicaid Eligibility," Medical Care, Vol. 17:9. September 1979, pp. 953-966.

A8. Lane, James A., "Encouraging Medicaid Participation in Medicare and Medicaid," Proceedings of the 28th Group Health Institute, New York (Group Health Association of America: District of Columbia, 1978).

A9. Lusen, Barbara, "Should There Be a Medicaid Contract in Your Future," Group Health Institute (Group Health Association of America, Washington, D.C.: 1979).

A10 Michian Department of Social Services,"Medicaid Reimbursement Methodologies and the Control or Avoidance of Costs," Unpublished Monograph, Michigan Department of Social Services. 1977.

A11 Mullooly, John and Donald K. Freeborn, "The Effect of Length of Membership Upon Utilization of Ambulatory Care Services," Medical Care, Vol. 17:9.

A12 Owen, Elizabeth W., "Measurement of Patient's Attitudes in HMOs: Can Medicaid Consumers Tell Us Where It Really Hurts?", Presented at the Annual Meeting of the American Public Health Association, Los Angeles, 1978.

A13 Rubin, David, Patricia Bench and Norman Fuller, "Drug Prescription Rates Before and After Enrollment of a Medicaid Population in an HMO," Public Health Reports, Vol. 93:1, Jan-Feb. 1978, pp. 16-23

A14 Sheridan, Bart, "At Last - A Medicaid Program That Works," Medical Economics, June 12, 1978, pp. 37-43.

A15 Spitz, Bruce, "When a Solution Is Not A Solution: Medicaid and Health Maintenance Organizations," Journal of Health Politics, Policy and Law, Vol. 3:4, Winter 1979, pp. 497-518.

A16 Strumpf, George, "Public Payor Participation In HMOs," Presented at conference: The Performance of Prepaid Care in the United States, November 1979, Boston.

A17 U.S. Department of Health and Human Services Health Care Financing Administration, "Medicaid HMO Experience Survey," Unpublised Manuscript, 1979.

A18 Wollstadt, Irving, Jan Shapiro and Thomas Bice, "Disenrollment From A Prepaid Group Practice: An Actuarial and Demographic Description," Inquiry, Vol. 15:2, June 1978, pp. 142-150.

The following references were provided by the State of California, Department of Health Services, Prepaid Health Research, Evaluation and Demonstration Project (PHRED Project). Project staff have indicated that most, if not all of these publications, would be available in the late Fall of 1980. All those not immediately available may be ordered in advance. See the introductory narrative for a description of the PHRED Project and its activities (Section IV).

A19 Request copies from, PHRED Projct, 455 Capitol Mall, Suite 250 Sacramento, CA 95814.

Rate-Setting and Fiscal Analysis

a. "Rate Guide for Prepaid Medicaid Contracts, Report No. 7," HCFA and Demonstration Series, August 1978.

One of the final products of the PHRED rate-setting demonstration, specifically intended as a reference document for state Medicaid agencies. (May also be ordered directly from HCFA.)

b. "Prepaid Health Plan Rate Development Analysis for FY 78-79 Rates," 30 June 1978.

Contains California's first instance of applying the principles described in the Rate Guide (above); details complete rate development analysis, beginning with statistics reported by each PHP.

c. "Selective Risk-Sharing: A New Reimbursement Alternative," 9 January 1979.

Describes a new risk-sharing concept developed during PHRED's ratesetting demonstration, its application in California's FY 78-79 PHP rates, and discussion of possible application for hospital inpatient reimbursement.

d. "Still Another Hospital Reimbursement Idea: Selective Risk-Sharing," 14 November 1978.

A more popularized treatment of the selective risk-sharing concept adapted to hospital reimbursement. If you order No. 3 above, you probably don't need this one.

e. "The FCHP Audit Exception: Evaluation of the Adverse Selection Hypothesis," 27 July 1977.

Foundation Communtiy Health Plan (FCHP) was an IPA-model PHP that in the eight years of California's PHP program received capitation rates higher than the fee-for-service per capita costs in the same service area. HEW found this to be in conflict with Federal law and declared an audit exception. The State contended that FCHP had experienced adverse selection, so that the high rates were justified. It became one of the agenda items for the PHRED Project to resolve this issue. This report summarizes the findings.

f. "Evidence for Cost Reduction Impact of PHP Contract," 5 April 1978.

An internal memorandum containing a concise recapitulation of the case for PHP (HMO) cost control.

Quality Assurance

g. Excerpt from "Proposal to Demonstrate a Quality Assurance Monitoring System," April, 1977.

The excerpt comprises the "Objectives" and "Background and Significance" sections of this grant proposal, for which a $1.8 million award was made in December 1977. These sections discuss quality assurance monitoring issues as perceived by the PHRED staff.

h. "Quality Assurance Criteria Set," Volumes 1 and 2.

The first phase of PHRED's quality assurance demonstration produced a set of quality of care criteria statements oriented to the PHP setting. Volume 1 contains these statements in the "natural language" version and Volume 2 contains quotations from the medical literature that substantiate the criteria.

Membership Studies

i. Excerpt from "Proposal to Demonstrate Marketing-Enrollment and Grievance Disenrollment Systems," December 1977.

The excerpt comprises the "Background and Importance" section and the 12-page bibliography from this grant proposal, for which a $1.4 million award was made in July 1978. This section discusses the issues of marketing and member satisfaction for Medicaid contracts with HMOs.

j. "Grievance-Disenrollment Procedures," June 1978.

A model grievance-disenrollment process recommended for use in California's PHPs. Satisfies Federal requirements for qualified HMOs and California's licensure requirements, as well as requirements under California's Medicaid contracting law.

k. Information folder for dual choice projects.

This folder describes to the Medi-Cal beneficiary the choice between fee-for-service and prepaid care in California.

l. "Measurement of Patient Attitudes in HMOs: Can Medicaid Consumers Tell Us Where it Really Hurts?" October 1978.

Discussion of issues of measuring Medicaid member satisfaction, presented at APHA annual meeting.

m. "Mainstream Marketing for Medicaid: What Works, What Doesn't (Seem To), and Why"

A preliminary report on the marketing demonstration results from the PHRED Project; delivered at the Group Health Institute Annual Meeting on 5 May 1980.

General

n. "A Manual for the Evaluation of Prepaid Health Plans," DHS program staff, 1978.

This is the procedure manual prepared by the staff in the California Department of Health Services who are responsible for assessing PHP contract compliance.

o. Standard California PHP contract, January 1979.

The current standard contract used in California's PHP program.

The following documents, resulting from PHRED research in Membership Studies and Quality Assurance, are in various stages of preparation. Titles and descriptions listed may be ordered for later delivery. These documents are expected to be available by October 1980:

Quality Assurance

p. "Criteria for Evaluating Quality in HMOs"-Volume III

The translation into computer language of the "natural language" criteria in Volume I.

q. "Medical Quality Assessment: The Evolution of an Experimental Medical Care Criteria Set"

A working paper chronicle of the 1978 experience of a distinguished panel of California providers and PHRED Project staff in developing a set of 332 medical care criteria for use in assessing quality of care in California HMOs.

r. "The Role of Utilization Statistics in Monitoring Health Maintenance Organizations: A Comparative Study of Utilization in Selected US HMOs."

A report which presents an analysis of utilization rates for Medicaid beneficiaries in selected Health Maintenance Organizations across the United States.

s. "Peer Review Practices in California Prepaid Health Plans"

Descriptions of the peer review practices of 14 California prepaid health plans from composition of the peer review panel to follow-up and feedback activities.

t. "Report on PHACES, Including Documentation"

Report of the operation of the Prepaid Health Ambulatory Care Evaluation System (PHACES), a computerized data assessment module which screens criteria against medical encounter data to generate potential exceptions to quality of care. This module is a part of the "Monitor Method", one of the two approaches being tested by the PHRED Project in the quality assurance demonstration. This report also includes translation of criteria to guidelines for use in the demonstration.

u. "EDAM Manual"

A final report on the operation of the Encounter Data Acquisition Module (EDAM), a computerized data acquisition module which collects and edits medical encounter and Medicaid eligibility data. This module is part of the "Monitor Method", one of the two approaches being tested by the PHRED Project in the quality assurance demonstration.

v. "Report on the Selective Data Acquisition Experiment"

History and results of demonstration of mini-computer application using the PHRED criteria set to assess quality of care in California HMOs. The "Selective Data Acquisition Method" is one of the two methods being tested by the PHRED Project in the quality assurance demonstration. (The report will be prepared by the Kaiser Research Center, which carried out this demonstration through a contract with PHRED.)

w. "Synthesis and Documentation of the PHRED Quality Assurance Demonstration"

An overview of the goals and experience of the tests of the PHRED quality assurance data acquisition methods, including a comparative evaluation, and a discussion of the relationship of the Project's results to current quality assessment issues.

x. "Staging--Technical and Final Report"

The results of the application of the "Staging"concept to assess quality of care in California HMOs. (This report will be prepared by SysteMetrics, which carried out the demonstration through a contract with PHRED.)

y. "Quality Assurance Standards Referenced in State HMO Legislation"

A Project working paper which describes and compares quality assurance standards embodied in the statutes of states which regulate Health Maintenance Organization (HMOs).

Membership Studies

z. "Comparative Analysis of Other State HMO Marketing Laws"

A report which describes and compares the HMO marketing statutes in those States which regulate HMOs.

a.a."Report on Results of PHRED's Marketing Enrollment Demonstration"

Analysis of the application in selected California county welfare offices of five methods of providing information on Medicaid options to Medicaid beneficiaries. The five methods are evaluated and compared with a control method, door-to-door solicitation, and mass mailing of information. Includes a survey of literature

b.b. "Medicaid Marketing Manual for State Agencies."

Describes six methods for State Medicaid agencies to use in offering a dual choice (fee-for-service card and HMO(s)) to Medicaid beneficiaries in welfare eligibility process and through mailings. Includes model marketing materials, choice forms, and issues and guidelines for implementation.

c.c. "Report on PHRED Grievance-Disenrollment System Demonstrations"

Report on the effects of implementing a model grievance and disenrollment system in five HMOs in California, including a copy of the revised model and description of training programs for consumer committees.

d.d. "Grievance-Disenrollment System for State Agencies"

A guide for the development of grievance and disenrollment systems within HMOs with the training of HMO consumer advisory committees as a integral component. Includes model system description, forms, and a model training program for consumer advisory groups.

e.e. "Report on PHRED Satisfaction Surveys Research (1977-79)"

Results and evaluation of satisfaction surveys administered to a selected prepaid and fee-for-service Medicaid population in the State of California over a three-year period. Includes comparison of Medicaid population's response to scale items used in national health services opinion surveys.

f.f. "Analysis and Report on PHRED's Dissatisfaction Survey"

A report on the use and effectiveness of a phone survey designed to measure dissatisfaction. The survey is based upon a sample of those persons who voice dissatisfaction through a model grievance system in California HMOs including those who disenroll from the health plans.

g.g. "Report on a Method to Gather Medicaid Consumer Opinion"

Evaluation of an opinion survey mailed to samples of California PHP and fee-for-service Medicaid clients designed to provide consumer input to State managers on health-related issues.

h.h. "Survey Manual for State Agenies"

A manual for State agencies describing satisfaction, dissatisfaction, and consumer opinion survey techniques which can be applied to HMO Medicaid populations.

i.i. "Model Training Program for Consumer Committees"

A training program designed to develop the skills of HMO Medicaid consumer advisors in identifying, analyzing, and recommending solutions to problem areas within HMOs. (Also included in 29 and 30 above.)

j.j. "List of California Community Organizations"

A listing of community organizations in California which are concerned about health-related issues.

*U.S. GOVERNMENT PRINTING OFFICE: 1981-0-728-187/1789

CMS LIBRARY
3 8095 00014256 8

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Public Health Service
Office of the Assistant Secretary for Health
Office of Health Maintenance Organizations
Rockville, Maryland 20857

DHHS Publication No. (PHS) 81-50168